

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00755

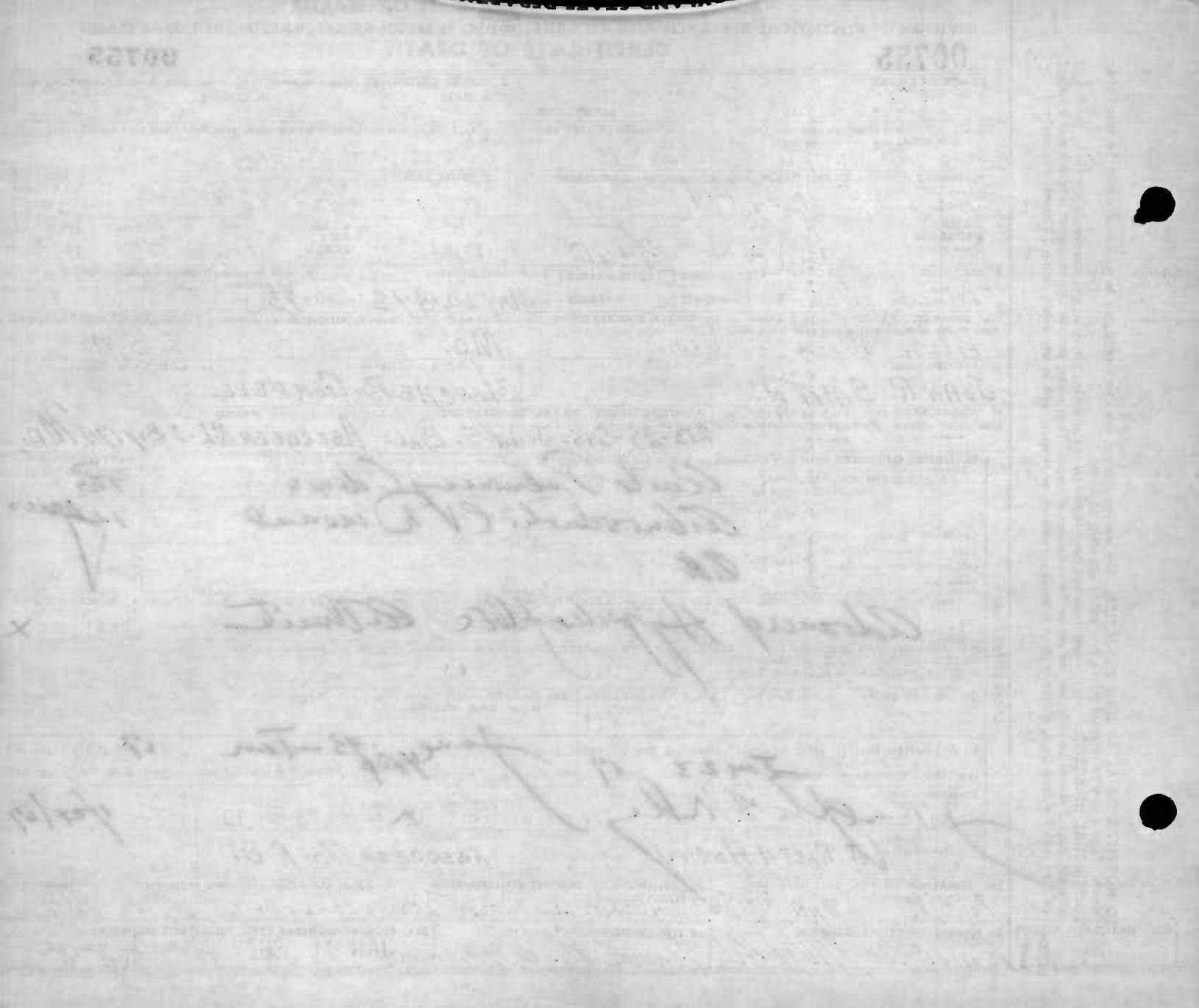
00755

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

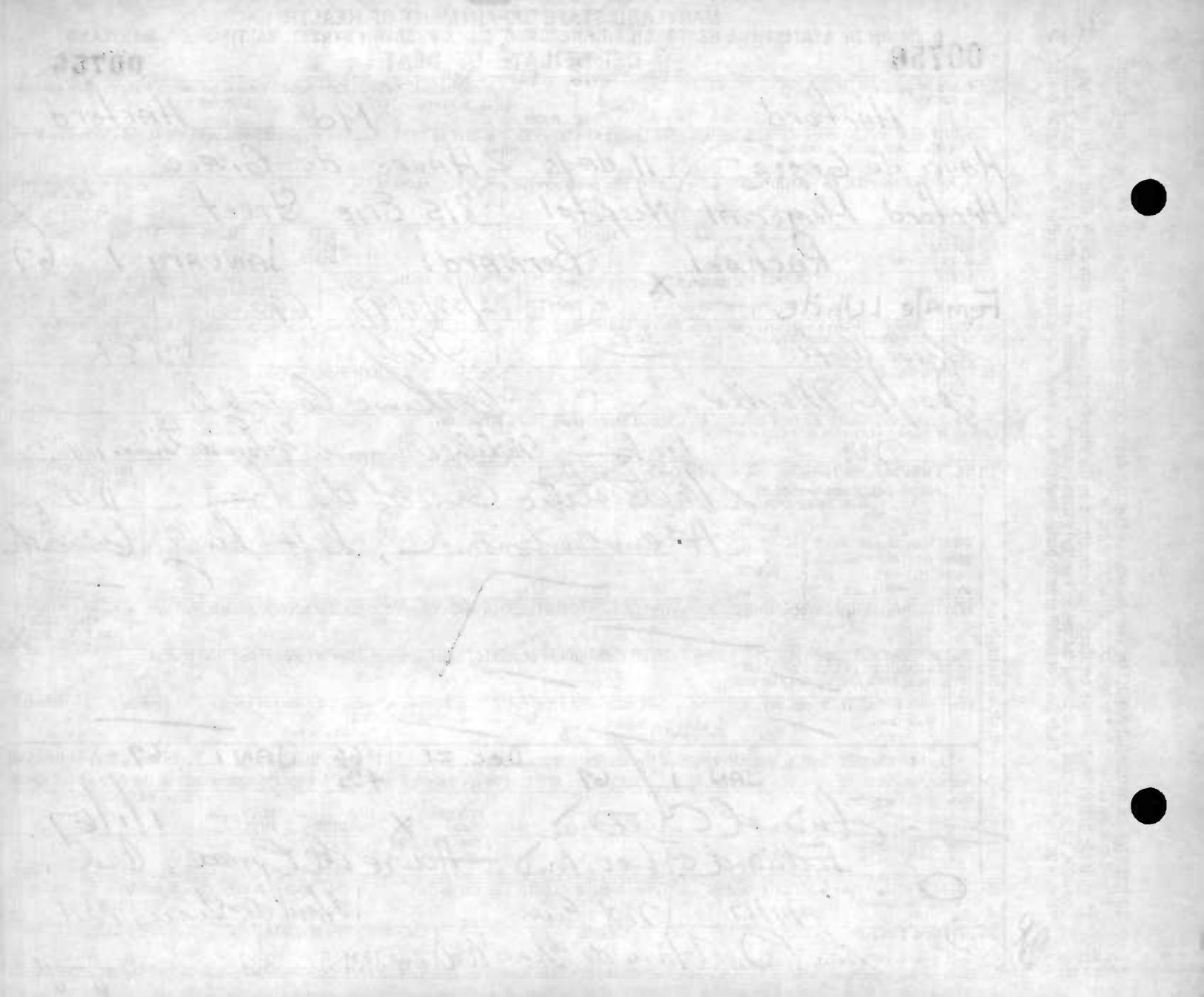
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
HARFORD		b. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
RURAL ABERDEEN		RURAL ABERDEEN	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
30 YRS		12.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
RE. O. #2 1304 1964		13. FATHER'S NAME	
3. NAME OF DECEASED (Type or print)		First	Middle
ANNA		MAUD	BALL
4. DATE OF DEATH		Month	Day
MAY 20, 1893		JAN	23
5. SEX		6. COLOR OR RACE	7. MARRIED
FEMALE		WHITE	<input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		73 yrs.	11. IF UNDER 24 HRS. Hours Min.
HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME		11. BIRTHPLACE (County & State, or foreign country)	U.S.A.
JOHN R. SMITH		MO.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
		213-38-5452	JOHN S. BALL, ABERDEEN R.R. 2 Box 174, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
HARFORD		702	
DUE TO		12 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		b. Pulmonary Edema	
} DUE TO		Cirrhovascular C.V. Disease	
} DUE TO		Cirrhosis	
} DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Advanced Hypertrophic Cardiome		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>January 23, 1967</u> , to <u>Jan 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 23, 1967</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.		22b. DATE SIGNED 1/26/67	
22a. SIGNATURE <u>J. Ralph Horley</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>J. Ralph Horley</u>		22d. ADDRESS ABERDEEN, MD. P.D.	
23a. BURIAL, CREMATION, REMOVAL* (Specify) BURIAL		23b. DATE THEREOF JAN. 27, 1967	
23c. NAME OF CEMETERY OR CREMATORIUM CHURCHVILLE PRESBYTERIAN		23d. LOCATION (City, town or county) HARFORD, Co. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell, Harford Grace, Md.</u>		25a. REC'D BY REGISTRAR DATE JAN 30 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
Item 8,9 11/18/67													
00756 00756													
1. PLACE OF DEATH a. COUNTY		Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Havre de Grace		11 days		a. STATE		Md					
c. LENGTH OF STAY IN 1b						b. COUNTY		Harford					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Harford Memorial Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Havre de Grace 12-1					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	1898	9. AGE (In years last birthday)	64	10. 12. COUNTRY?	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.			
Female		White		2/22/1898		64	68 yrs.	U.S.A.					
10a. USUAL OCCUPATION (Give kind of work done during most or working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT							
House Wife				Italy		CATHARINE COSTABILE							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE - (a)			
Joseph Mavillo		Catharine Costabile		No.		615 Erie St., Havre de Grace, Md.		Address		163X Metastatic Ca. of the Brain.			
16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE - (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH					
				163X Metastatic Ca. of the Brain.		NO		11 days					
19. MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 21, 1966, to JAN 1, 1967, that (I) (we) last saw the deceased alive on JAN 1, 1967, and that death occurred at 4:30 P.M., from the causes and on the date stated above.		22a. SIGNATURE		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		1/1/67			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)							
1/4/67		1/4/67		Mt. Zion		Havre de Grace, Md.							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Patterson & Son, Havre de Grace, Md.				DATE JAN 5 1967		Charles Judge							
VR A15 (4) 15M 4-64													



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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00757

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)		a. STATE Md		b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Harve-de-Grace 2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		118 E. Main St, Elkton		d. STREET ADDRESS 118 E. Main St		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First Cleanora	Middle Mae	Last Biles	4. DATE OF DEATH	1	Month	11	Day	1967
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1894	9. AGE (in years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Woolworth		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME John T. Lilley		14. MOTHER'S MAIDEN NAME Cramer		Lilley, Sarah						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Gifford B. Biles, Elkton, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X		Cardio Vascular failure 30 min.								
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b) C V A. Cerebral Hemorrhage (massive)		2 hrs.						
		DUE TO (c) Hypertension I-H. C. V. D.		years						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1-15, 1960, to 1-11, 1967, that (I) (we) last saw the deceased alive on 4-11-1967, and that death occurred at 5:30 P.M., from the causes and on the date stated above.		22b. DATE SIGNED 1/11/67								
22a. SIGNATURE Luis M. Cuza		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 322 E. Cecil Ave. North East, Md.								
22c. PHYSICIAN'S NAME (Type) Luis M. Cuza M.D.		23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 1/14/67 23c. NAME OF CEMETERY OR CREMATORIUM St. Mary Anne's Cemetery, North East, Md.								
24. FUNERAL DIRECTOR Ralph E. Hicks		23d. LOCATION (City, town or county) (State) 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE								
		ADDRESS Hicks Home for Funerals, Elkton, Md. DATE JAN 13 1967 Charles Judge								
VR A15 (4) 15M 4-64										

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY	Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Hardegrace 31 days			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	DARLINGTON, Md.		
d. LENGTH OF STAY IN 1b				d. STREET ADDRESS	Smith Rd.		
e. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Harford Memorial Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Male	Williams	Joseph	Bostic	1	11	19	67
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	SEPT 13, 1891	75 yrs.	CARPENTER	Md.	U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?				
RETIRED	CARPENTER	Md.	U.S.A.				
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	Address					
JOSEPH	HANNAH MAIN						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH				
YES WWI	162-09-3131A	Wm. F. Bostic, HARVE DE GRACE, MD.	22 days				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Penetrating car accident</i>						
33IX	DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)	(c)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
19							
21. I certify that (I) (this hospital) attended the deceased from 10-22, 1967, to 1-11, 1967, that (I) (we) last saw the deceased alive on 1/11/1967, and that death occurred at <i>100</i> M, from the causes and on the date stated above.				22a. SIGNATURE <i>Dudley Phillips</i>	22b. DATE SIGNED 1/12/67		
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS <i>Dudley Phillips, MD</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City, town or county) (State)				
BURIAL	1-14-67	DARLINGTON	DARLINGTON, MD				
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE				
John H. Harberia, DELTA, PA.		DATE JAN 17 1967	Charles Judge				

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground DOA		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital		d. STREET ADDRESS Box 24-A Northeast Rd.	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle C. Last BRINEGAR		4. DATE OF DEATH Month January Day 23 Year 19 67	
5. SEX Male White		6. COLOR OR RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10 July 1923		9. AGE (In years last birthday) 43 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman-Heavy Equip. Sect. U.S. Govt. Wilkes Co., N.C.		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William K. Brinegar		14. MOTHER'S MAIDEN NAME Clyde Taylor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service) Yes WW-II		16. SOCIAL SECURITY NO. 238-22-7314	
17. INFORMANT Van Brinegar, Aberdeen, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Hyperensive Cardiovascular Disease 1048	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) this hospital attended the deceased from 3-5-67, 19, to 1-23-67, 19, that (I) (we) last saw the deceased alive on 1-20-67, 19, and that death occurred 11:50M, AM, causes and on the date stated above.		22b. DATE SIGNED 1-24-67	
22a. SIGNATURE Peter P. Rodman		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Peter P. Rodman		22d. ADDRESS 8 Law Street, Aberdeen, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 25 Jan. 67	
23c. NAME OF CEMETERY OR CREMATORIAL Whitehead Cemetery		23d. LOCATION (City or Town) (County) (State) Whitehead, North Carolina	
24. FUNERAL DIRECTOR Wesley Macaulay Jr.		25a. REC'D BY REGISTRAR Tarring & Funeral Home	
		25b. REGISTRAR'S SIGNATURE Charles Judge	
		DATE JAN 26 1967	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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CERTIFICATE OF DEATH

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<i>Harford</i> MARYLAND		b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace, Md.</i>	
c. LENGTH OF STAY IN 1b <i>Lifetime</i>		d. STREET ADDRESS <i>612 S. Union Ave.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Citizens Nursing Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Elizabeth E. Brown</i>		4. LAST	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 23, 1903</i>
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) <i>63 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Harford County, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Thomas Barrett</i>		14. MOTHER'S MAIDEN NAME <i>Laura Hall</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-16-2749A</i>	
17. INFORMANT <i>Mrs. Matel E. Barrett, Havre de Grace, Md.</i>		Address <i>612 S. Union Ave.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatous with Cerebral Involvement</i>			
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____			
DUE TO (c) <i>Carcinoma of the Colon</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>10/18</i> , 1966, to <i>11/17</i> , 1967, that (I) (we) last saw the deceased alive on <i>11/16</i> 1967, and that death occurred at 2:20 AM, from the causes and on the date stated above.		22b. DATE SIGNED <i>11/19/67</i>	
22a. SIGNATURE <i>George T. Stansbury</i>		22c. PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan. 21, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Asbury Methodist Cem.</i>
24. FUNERAL DIRECTOR <i>Otelia J. Bullock, Havre de Grace, Md.</i>		23d. LOCATION (City, town or county) (State) <i>Churchville, Harford Co., Md.</i>	
25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

03700

03700

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00761

CERTIFICATE OF DEATH

00761

1. PLACE OF DEATH a. COUNTY Harford MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood		c. LENGTH OF STAY IN 1b 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood 12.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2016 Armstrong Street			d. STREET ADDRESS 2016 Armstrong Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ANTHONY	Middle -	Last BURBAR	4. DATE OF DEATH JANUARY 5 1967	Month JANUARY	Day 5	Year 1967
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1897	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sgt.		10b. KIND OF BUSINESS OR INDUSTRY USA - Retired		11. BIRTHPLACE (County & State, or foreign country) Sima, Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anthony Burbar				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI and WWII			16. SOCIAL SECURITY NO. 215-24-6948	17. INFORMANT Mrs. A. Ellen Burbar, 2016 Armstrong St.,			Address Edgewood, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure							INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Pulmonary heart disease							5 years
DUE TO (c) Pulmonary emphysema							20 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Kirk Army Hospital	(County) APG	(State) Md.	
21. I certify that (I) Kirk Army Hospital attended the deceased from April 19 66 to January 19 67 , that (I) (we) last saw the deceased alive on 16 December 1966 , and that death occurred at 4:00 PM from causes and on the date stated above.							22b. DATE SIGNED
22a. SIGNATURE Ronald M. Severino		M.D. <input type="checkbox"/> ATTENDING PHYS. RONALD M. SEVERINO, CAPTAIN, MC	MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Kirk Army Hospital, APG, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 9, 1967	23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery	23d. LOCATION (City or Town) Ft. Myer	(County) APG	(State) Md.		
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE JAN 9 1967	25b. REGISTRAR'S SIGNATURE Charles Judge				

2700

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00762

CERTIFICATE OF DEATH

00762

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M		25		2		2		2		2		2			
1. PLACE OF DEATH a. COUNTY		Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)		a. STATE Maryland		b. COUNTY Harford		3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		12.1				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		143 Thomas St.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Aberdeen Proving Ground				Bel Air						Kirk Army Hospital					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS						e. IS RESIDENCE ON A FARM?					
25		143 Thomas St.		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First Robert		Middle Allen		Last CHANDLER		4. DATE OF DEATH		Month Jan		Day 4		Year 1967	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.			
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		31 January 66		yrs. 11 3		Months 11		Days 3		Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?									
None		N/A		Harford, Maryland		USA									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME													
Andrew L. Chandler		Bonnie C. Fuller													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address									
No		-		Father (Same as above)											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]														INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration														3 Days	
493X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Vomiting															
DUE TO (c) Pneumonia															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
Hour a.m.				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
p.m.		19													
21. I certify that (I) (REMOVED) attended the deceased from 4 Jan 1967, to 4 Jan 1967, that (I) (REMOVED) last saw the deceased alive on 4 Jan 1967, and that death occurred at 9:00 AM, from the causes and on the date stated above.														22b. DATE SIGNED	
22a. SIGNATURE		22b. DATE SIGNED													
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS													
WILLIAM J. PETER, CPT., MC		Kirk Army Hospital, APG, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		(State)							
Burial		7 Jan. 67		Bel Air Memorial Gardens, Bel Air, Maryland											
24. FUNERAL DIRECTOR		Tarring Funeral Home		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
John G. Tarring		Aberdeen, Md.													
DATE JAN 6 1967		Charles Judge													

2527

34500

1. *Environ. Monit. Assess.*

2000-2001

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00763

CERTIFICATE OF DEATH

00763

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)				
Harford		Maryland		3 days		a. STATE Md				
						b. COUNTY Harford				
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
						Abingdon				
						12-1				
						d. STREET ADDRESS				
						3801 Old Phila. Rd.				
						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
Howard Emory				Coe	January	14	1967			
5. SEX		6. COLOR OR RACE	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR 11. IF UNDER 24 HRS.			
Male		White			August 14, 1878	88	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Former Proprietor		Farm		Harford Co., Maryland		USA				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME								
Moses P. Coe		Elizabeth Butler								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No		212-38-4829		Mrs. Walter R. Famous, 3108 Old Phila Rd.		Abingdon, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN DNSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		561.0		Generalized A.S.O.C.V.D c. C.V.A.						
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		Dehydration						
		(c)		Incongested & engorged larynx						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)		
19										
21. I certify that (I) (this hospital) attended the deceased from JAN 12, 1967, to JAN 14, 1967, that (I) (we) last saw the deceased alive on JAN 14, 1967, and that death occurred at 12 AM, from the causes and on the date stated above.						22b. DATE SIGNED				
22a. SIGNATURE						14 Jan. 1967				
22c. PHYSICIAN'S NAME (Type)		HENRY H. KWON		22d. ADDRESS		608 S. Union Ave. Harford Co.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county) (State)				
Burial		Jan. 16, 1967		Jarrettsville Cemetery		Jarrettsville, Harford Co. Md.				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
		Howard K. McComas & Son, Abingdon, Md. 21009				J. Charles Judge				
				DATE JAN 17 1967						

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

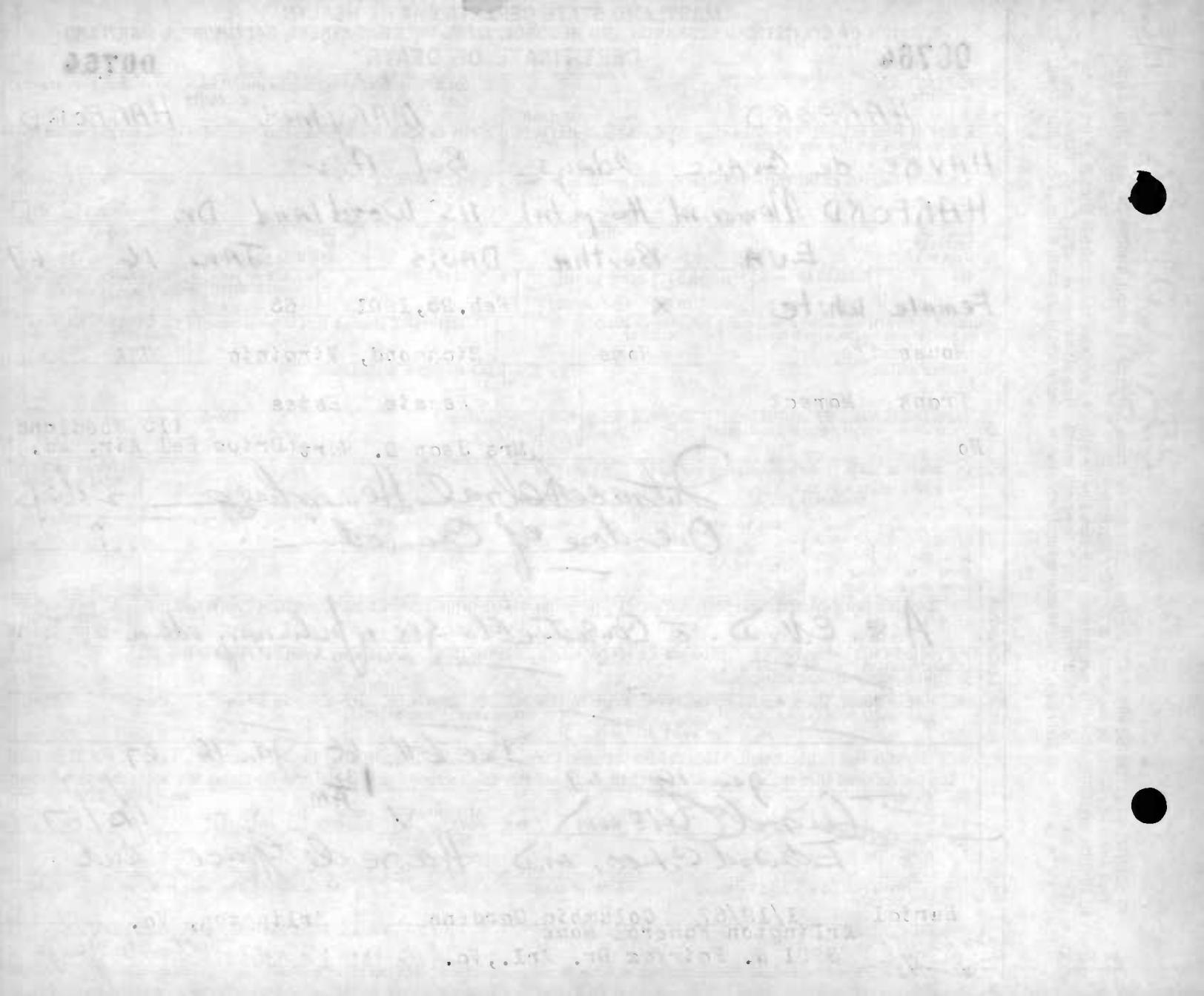
CERTIFICATE OF DEATH

00764

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE							
HARFORD MARYLAND		MARYLAND							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b							
HARFORD		2 days							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
HARFORD Memorial Hospital		115 Woodland Dr.							
3. NAME OF DECEASED (Type or print)		First	Middle						
EVA		Bertha	DAVIS						
4. DATE OF DEATH		Month	Day						
JAN 16		1967							
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS		
Female		white		Feb. 25, 1901	65 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife		Home		Richmond, Virginia		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Frank Mareck		Bessie Estes							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
				Mrs. Jean D. Hart (Drive Bel Air, Md.)		115 Woodland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Intracranial Hemorrhage				2 days			
331 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		Over-dose of Coumadin				?			
DUE TO (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		A.S. C.V.D. & Congestive Changes & Pulmonary edema				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not-White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
19									
21. I certify that (I) (this hospital) attended the deceased from Dec 6th, 1966 to Jan 16, 1967, that (I) (we) last saw the deceased alive on Jan. 16, 1967, and that death occurred at 35 M, from the causes and on the date stated above.									
22a. SIGNATURE		Edward C. Loo, M.D.				22b. DATE SIGNED			
						AM (1/16/67)			
22c. PHYSICIAN'S NAME (Type)		Edward C. Loo, M.D.				22d. ADDRESS			
Burial		Havre de Grace, Md.				Arlington, Va.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)		(State)	
Burial		1/19/67		Columbia Gardens		Arlington, Va.			
24. FUNERAL DIRECTOR		Arlington Funeral Home		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
		3901 N. Fairfax Dr. Arl., Va.					Charles Judge		
						DATE JAN 19 1967			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
hours

Health
Outcomes

00765

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00765

1. PLACE OF DEATH o. COUNTY Harford			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hayre de Grace		c. LENGTH OF STAY IN lb DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital			d. STREET ADDRESS 26 Center St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) Richard		First Richard	Middle Wilson	Lost Dorsey, Jr.	4. DATE OF DEATH Month 1
S. SEX male	6. COLOR OR RACE colored	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1927	9. AGE (In years and birthday) 39 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY A.P.G.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Richard W. Dorsey Sr.			14. MOTHER'S MAIDEN NAME Elsie P. Thomas		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1945-49		16. SOCIAL SECURITY NO. 217-20-2063	17. INFORMANT Elsie P. Dorsey, Port Deposit, Md.	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Massive left hemothorax DUE TO (b) Stab wound of neck involving subclavian artery DUE TO (c) and lung.					
INTERVAL BETWEEN ONSET AND DEATH 982X					
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause lost.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) stabbed during altercation			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 3:30 AM 1 21 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) Port Deposit	(County) Cecil
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 1/21/67	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-25-67	23c. NAME OF CEMETERY OR CREMATORIAL Jones Memorial Cem	23d. LOCATION (City or Town) Port Deposit, Md.	(County) (State)
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE
DATE FEB 1 1967					

62700

12000

62700



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00766

CERTIFICATE OF DEATH

00766

1. PLACE OF DEATH a. COUNTY		Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)		Item 7 Film 6385 114472	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Havre de Grace		c. LENGTH OF STAY IN 1b		a. STATE		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Harford Memorial Hospital		27 hrs.		Md		Harford	
e. STREET ADDRESS		353 Congress Ave		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Havre de Grace		121	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	12. IF UNDER 24 HRS.	
Female		White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	3/31/1902	64 yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Clerk		Drug Store		Havre de Grace, Md		a. SA.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
George Broadwater		Grace Daffish							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		INTERVAL BETWEEN ONSET AND DEATH	
no		unk		Vincent Broadwater, Havre de Grace				2 days	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO									
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) JAN 15 1967	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from JAN 15, 1967 to JAN 16, 1967, that (I) (we) last saw the deceased alive on JAN 16 1967, and that death occurred at 10 AM, from the causes and on the date stated above.									
22a. SIGNATURE John H. McDonald									
22b. DATE SIGNED 1/17/67									
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS			
23a. BURIAL/CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1/19/67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Angel Hill		23d. LOCATION (City, town or county) Havre de Grace, Md		(State)		
24. FUNERAL DIRECTOR		ADDRESS Tammington Park, Havre de Grace, Md		25a. REC'D BY REGISTRAR DATE JAN 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 (4) 15M 4-64									

9700

1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00767

1. PLACE OF DEATH

a. COUNTY

HARFORD

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Aberdeen

MARYLAND

c. LENGTH OF STAY IN 1b

9 days

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Kirk Army Hospital

3. NAME OF DECEASED
(Type or print)

Fir Margaret

Middle Irene

Last Emory

4. DATE
OF
DEATH

28

Jan

1967

5. SEX

F

6. COLOR OR RACE

CAU

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

24 JULY 80

9. AGE (in years
last birthday)

86

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (County & State, or foreign country)

XXXXXX FT HANCOCK NJ

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

DAVIO BURDUNN

14. MOTHER'S MAIDEN NAME

MARY O'NEILL

Address

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

NO

16. SOCIAL SECURITY NO.

N/A

17. INFORMANT

Estelle E. Murphy

Arlington, Va.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (e)

199.2

Carcinomas

INTERVAL BETWEEN
ONSET AND DEATH

6 days

DEU TO

Conditions, if any, which
gave rise to immediate cause
(e), stating the underlying
cause last.

(b)

DEU TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. MEDICAL CERTIFICATION

20b. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. While Not While
p.m. at work at work

20d. INJURY OCCURRED
20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that (I) (this hospital) attended the deceased from 19 JAN 1967 to 27 JAN 1967 that (I) (we) last
saw the deceased alive on 19....., and that death occurred at 0858 M, from the causes and on the date stated above.

22a. SIGNATURE

Thomas J Fraher M.D.

ATTENDING
PHYS.

MED.
DIRECTOR

STAFF
PHYS.

22b. DATE
SIGNED
28 Jan. 1967

22c. PHYSICIAN'S
NAME (Type)

Thomas J FRAHER KAH DPG MD

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial 31 Jan. 67 Arlington National Cem. Arlington, Virginia

23c. NAME OF CEMETERY OR CREMATORIAL

23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE

Tarring Funeral Home Aberdeen, Maryland

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

JAN 30 1967

Judge

Dates

10700

10700

10700

10700

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10700

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1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00768

00768

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND		2			
M		00768		00768			
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY		a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>					
<u>HARFORD</u>		MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b					
<u>HAURE de GRACE</u>		6 days					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS					
<u>HARFORD Memorial Hosp.</u>		<u>Perryville</u> 07-2					
e. IS RESIDENCE ON A FARM?		e. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <u>ANNA</u>	Middle <u>Margaretha</u>	Last <u>Fadeley</u>	4. DATE OF DEATH <u>January 14 1967</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14 1891</u>	9. AGE (In years last birthday) <u>75</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>A.S.A.</u>							
13. FATHER'S NAME <u>James Worth</u>		14. MOTHER'S MAIDEN NAME <u>Anna A. Bradford</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Chas. O. Fadeley, Perryville Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4331</u>		<u>Cardiac Arrest</u> <u>minutes</u>					
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac arrhythmia</u>							
(c) <u>Cholecystectomy for empyema of gall bladder</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>HAURE de GRACE, Md.</u>	(County) <u>Perryville</u> (State) <u>Md.</u>
21. I certify that (I) (this hospital) attended the deceased from <u>1-9</u> , 19 <u>67</u> , to <u>1-14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-14</u> , 19 <u>67</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.						22b. DATE SIGNED	
22a. SIGNATURE <u>Charles J. Foley Jr.</u>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) <u>CHARLES J. FOLEY JR.</u>		22d. ADDRESS <u>HAURE de GRACE, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/17/1967</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Principia Cemetery</u>		23d. LOCATION (City, town or county) <u>Perryville, Cecil Md.</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR <u>See J. William & Son, Perryville Md.</u>		ADDRESS				25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
						DATE <u>JAN 23 1967</u>	

9-100

2370

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

00769

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00769

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN lb 3 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pulaski Motel US. #40		d. STREET ADDRESS Shamrock Diner		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HOWARD		First ROY	Middle ROY	Lost FIZER	4. DATE OF DEATH Month Day Year January 1 1967
5. SEX Male		6. COLOR OR RACE Cau.	7. MARRIED WIDOWED <input type="checkbox"/> <input checked="" type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Jan. 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurants		11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.	
13. FATHER'S NAME Andrew J. Fizer		14. MOTHER'S MAIDEN NAME Vally May Keys		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW-2		16. SOCIAL SECURITY NO. 184-05-1564		17. INFORMANT Elsie Dougan Address Havre de Grace, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1		IMMEDIATE CAUSE (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)			
		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Bel Air (County) Md. (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				22. DATE SIGNED 1-2-67	
ACTUAL SIGNATURE Gerald C. Palmer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gerald C. Palmer M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Bel Air, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 4, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Slateville Cemetery	
23d. LOCATION (City or Town) Delta (County) York (State) Penna.					
24. FUNERAL DIRECTOR John H. Harkins		ADDRESS Delta, Pa.		25a. REC'D BY REGISTRAR DATE JAN 4 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

earns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
6
00770 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH
00770

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Nant. Cecil</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>	c. LENGTH OF STAY IN 1b <i>8 hrs.</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>					
3. NAME OF DECEASED (Type or print) <i>Margary Bell Harvey</i>	First Last Middle	4. DATE OF DEATH Month Day Year <i>JANUARY 2 1967</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH <i>FEB. 2, 1936</i>	9. AGE (In years last birthday) <i>30 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gas & Elec. Clerk</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>utility Co.</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore City, Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Clyde Worrell Harvey</i>	14. MOTHER'S MAIDEN NAME <i>RUNE BELL</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No	16. SOCIAL SECURITY NO. <i>219-26-6475</i>	17. INFORMANT (Father) <i>Mr. Clyde W. Harvey</i> Address <i>363 Catherine St. Bel Air, Md. 21014</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intracerebral hemorrhage, rt. temporal</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <i>6 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>JAN 1, 1967</i>	(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>JAN 1, 1967</i> to <i>JAN 2, 1967</i> , that (I) (we) last saw the deceased alive on <i>JAN 2, 1967</i> , and that death occurred at <i>12 AM</i> , from the causes and on the date stated above.	22a. SIGNATURE <i>R. Caffer</i>	22b. DATE SIGNED <i>Jan 2, 1967</i>			
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS <i>Harford Memorial Hospital</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>JAN. 5, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>St. Ignatius Cath. Ch. Cem.</i>	23d. LOCATION (City, town or county) (State) <i>Hickory, Harford Co., Maryland</i>		
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>	ADDRESS <i>W. Broadway & Williams St. Bel Air, Maryland 21014</i>	25a. REC'D BY REGISTRAR <i>JAN 4 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Joseph William Foster</i>		

Fig. 1. $\sigma_{\text{tot}}^{\text{exp}}$ vs. $\sigma_{\text{tot}}^{\text{theor}}$.

1100

1 FOR STATE M
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00771

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00771

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Horford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Pa.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Kennedy Hwy. nr. White Marsh</i>		d. STREET ADDRESS <i>2503 W. Thompson St</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mapine</i>	First	Middle	Last <i>Hewlett</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <i>11/20/45</i>	9. AGE (In years lost birthday) <i>21</i> yrs.	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Dys <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sorter</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Philco Corp.</i>	11. BIRTHPLACE (State or foreign country) <i>Philadelphia Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Richard Hewlett</i>	14. MOTHER'S MAIDEN NAME <i>Ann Thones</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO.	17. INFORMANT <i>Hobson Reynolds, Philadelphia, Penn.</i>	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>multiple injuries</i> DUE TO 819.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Passenger in auto - into fixed object</i>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>4:46 pm 1-21-1967</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>street</i>	20f. (City or town) (County) (State) <i>Hayfield Md.</i>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Werner U. Spitz</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <i>1-21-67</i>
EXAMINER'S NAME (Type) <i>WERNER U. SPITZ, M.D.</i>	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>1-28-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Lawn</i>	23d. LOCATION (City or Town) (County) (State) <i>Philadelphia, Penna.</i>
24. FUNERAL DIRECTOR <i>Hobson Reynolds - 2042-44 Ridge Ave., Phila. Pa.</i>	ADDRESS	25a. REC'D BY REGISTRAR <i>JAN 25 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

X

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00772

CERTIFICATE OF DEATH

00772

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.1. PLACE OF DEATH
a. COUNTY

Hartford

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Hause-de-Grace

c. LENGTH OF STAY IN 1D

9 hrs.

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Hartford Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

.

4. DATE
OF
DEATH

Month

1

Day

15

Year

1967

5. SEX

Female

6. COLOR OR RACE

White

WIDOWED

DIVORCED

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

Nov. 10, 1961

5

yrs.

9. AGE (in years
last birthday)

5

Months

Days

10. IF UNDER 1 YEAR

Months

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

HAURE DE GRACE, MD.

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

Holloway, Bill

14. MOTHER'S MAIDEN NAME

Gibbs, Grace

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

WILLIAM HOLLOWAY, FOREST HILL, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)H91X
Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO

(b)

DUE TO

(c)

Acidosis, Menigitis, pneumo-
coniosis segment cardiac arrest
Belated BacteropneumoniaINTERVAL BETWEEN
ONSET AND DEATH

days

days

30 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m.
p.m.20d. INJURY OCCURRED
While Not While
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-18, 1967, to 1-18, 1967, that (I) (we) last
saw the deceased alive on 19, and that death occurred at 9:37 A.M. from the causes and on the date stated above.

22a. SIGNATURE

J. Ralph Harkay

22b. DATE SIGNED

1/18/67

22c. PHYSICIAN'S
NAME (Type)

J. Ralph Harkay

22d. ADDRESS

CHURCHVILLE, MD.

23a. BURIAL, CREMATION, DATE THEREOF
REMOVAL (Specify)

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county) (State)

Burial Jan. 21, 1967

Welcome Home

HICKORY, HARFORD Co., MD.

24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR

JAN 23 1967

25b. REGISTRAR'S SIGNATURE

Charles Judge

卷之三

4280

the young 25 years old, marked
with red paint on the forehead
and with a small
pomander stick.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00773

CERTIFICATE OF DEATH

00773

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford, Aberdeen		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen Prov. Gd		c. LENGTH OF STAY IN 1b 46 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2728-D West Ct., APG, Maryland		12.1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kirk Army Hospital		d. STREET ADDRESS APG, Aberdeen, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Willia Mae Hudson		First	Middle	Last	4. DATE OF DEATH 26 Feb 1899	Month Jan	Doy 8	Year 167
S. SEX Female	6. COLOR OR RACE Negro	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Feb 1899	9. AGE (In years lost birthday) 67 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Home School		11. BIRTHPLACE (County & State, or foreign country) San Antonio, Texas		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME UNKNOWN						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 527-24-0657D		17. INFORMANT LTC. Albert Justice		Address (same as above)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiac failure		INTERVAL BETWEEN ONSET AND DEATH 2 Days				
1561 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Liver Carcinoma		2 Years				
1561 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		Metastasis		2 Years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year 3:20 a.m. 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from 23 Nov 1967, to 8 Jan 1967, that (we) lost saw the deceased alive on 8 Jan 1967, and that death occurred at 0320aM, from causes and on the date stated above.								
22a. SIGNATURE John L. Butsch		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) JOHN L. BUTSCH, CPT., MC		22d. ADDRESS 413 Haslett Rd., Joppatowne, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 11 Jan. 67		23c. NAME OF CEMETERY OR CREMATORIAL HOME Evergreen Cemetery		23d. LOCATION (City or Town) (County) (State) Tucson, Arizona		
24. FUNERAL DIRECTOR John S. Tarrington		Tarrington Address Aberdeen, Md.		25a. REC'D BY REGISTRAR DATE JAN 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

2700

700

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00774

CERTIFICATE OF DEATH

00774

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>House de Grace</i>		c. LENGTH OF STAY IN 1b <i>13 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Belair</i>		d. STREET ADDRESS <i>RD 2; Thomas Run Rd</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH <i>JANUARY 18 1967</i>			
3. NAME OF DECEASED (Type or print) <i>Benjamin</i>		First	Middle	Last	Month	Day	Year
5. SEX <i>Male</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>April 1896</i>	9. AGE (In years last birthday) <i>70 yrs.</i>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>A. P. Ground</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>John Johnson</i>		14. MOTHER'S MAIDEN NAME <i>No record</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-18-4038</i>		17. INFORMANT <i>Mrs. Bertha P. Murray, Bel-Air, Md</i>		Address <i>RT 1 Box 394</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Central Thrombosis</i> <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) <i>Hypertension - Arterosclerotic Heart disease</i>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Urinary Tract Infection</i>							
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>3</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>569 Revolution St. House de Grace, Md.</i>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Dec. 30, 1966</i> , to <i>JAN. 18, 1967</i> , that (I) (we) last saw the deceased alive on <i>January 18 1967</i> , and that death occurred at <i>6 53 M</i> , from the causes and on the date stated above.						22b. DATE SIGNED <i>1/18/67</i>	
22a. SIGNATURE <i>George T. Stansbury</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>1/18/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>		22d. ADDRESS <i>569 Revolution St. House de Grace, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-22-1967</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Astbury Methodist Cem</i>		23d. LOCATION (City, town or county) (State) <i>Churchville Harford Co. Md.</i>	
24. FUNERAL DIRECTOR <i>John Bullock House de Grace, Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>JAN 23 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
				DATE			

22500 22500

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00775

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00775

1. PLACE OF DEATH a. COUNTY <i>Hanford</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen 121</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Old Level Rd. Rd. 2</i>		d. STREET ADDRESS Box 267 Westwood Manor Farm Old Level Road	
3. NAME OF DECEASED (Type or print) <i>Jessica Mae Johnson</i>		4. DATE OF DEATH <i>January 25, 1967</i>	Month Year
S. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED NEVER MARRIED WIDOWED DIVORCED <i>X</i>	8. DATE OF BIRTH <i>11-8-66</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>City Hospital Baltimore</i>	
11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>JESSIE JAMES Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Curton</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>JESSIE JAMES Johnson Churchville MD</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Singultation due to injured</i>			
DUE TO (b) <i>Vomitus</i> SD 11			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 3	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Carol C Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Bethel, MD</i> DATE SIGNED	
EXAMINER'S NAME (Type) <i>Gertrude Palmer</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Gertrude Palmer</i>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-7-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Bethel</i>
23d. LOCATION (City or Town) (County) (State) <i>Darlington Harford MD</i>		23e. REC'D BY REGISTRAR DATE JAN 10 1967	
24. FUNERAL DIRECTOR <i>George W. TITTLE BEL Air MD</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

67790

1960 BOUND EDITION

65.00

M
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00776 **00776**

1. PLACE OF DEATH
a. COUNTY **HARFORD** **MARYLAND**

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **FOREST HILL** **20 years**

c. LENGTH OF STAY IN lb
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Box 164 - FARM** **Jarrettsville Road**

3. NAME OF DECEASED (Type or print) **PAUL DONALD JOHNSON** First **Middle** Last **4. DATE OF DEATH** Month **JAN** Day **25** Year **1967**

5. SEX **MALE** **W** 6. COLOR OR RACE **7. MARRIED** **NEVER MARRIED** **B. DATE OF BIRTH** **Oct 14, 1924** 9. AGE (In years last birthday) **42 yrs.** IF UNDER 1 YEAR **Months** **Days** IF UNDER 24 HRS. **Hours** **Min.**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **FARMING** 10b. KIND OF BUSINESS OR INDUSTRY **Gen. farming** 11. BIRTHPLACE (State or foreign country) **Forest Hill, Maryland**

13. FATHER'S NAME **J. Raymond Johnson** 14. MOTHER'S MAIDEN NAME **Frances Wilson**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? **No** 16. SOCIAL SECURITY NO. **219-18-0522** 17. INFORMANT **Mrs. Lina R. Johnson** **Box 164 Jarrettsville Rd.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **INTERNAL HEMORRHAGE CHEST** DUE TO **92.1** INTERVAL BETWEEN ONSET AND DEATH **INSTANT**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **CRUSHING BY FARM TRACTOR** DUE TO **92.1**

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?
YES NO

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) **FARM TRACTOR ROLLED OVER, SIDE OF HILL**

20c. TIME OF INJURY Month, Day, Year **2:50 p.m. JAN 25 1967** 20d. INJURY OCCURRED While Not While at work at work **FARM** 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) **FOREST HILL, HARFORD, Md** 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE **Philip W. Heuman** CHIEF MEDICAL EXAMINER
EXAMINER'S NAME (Type) **PHILIP W. HEUMAN, M.D.** M.D. ASSISTANT MEDICAL EXAMINER SIGNED **JAN 25 1967**
22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF **1/28/1967** 22c. NAME OF CEMETERY OR CREMATORIAL **Bel Air Mem. Gardens** 22d. LOCATION (City, town, or country) **Bel Air** (State) **Maryland**

23. FUNERAL DIRECTOR **Charles E. Kurtz** ADDRESS **Jarrettsville, Md.** 24a. REC'D BY REGISTRAR **Charles Judge** 24b. REGISTRAR'S SIGNATURE

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with farm PM3. Page 5 may be retained for your files.

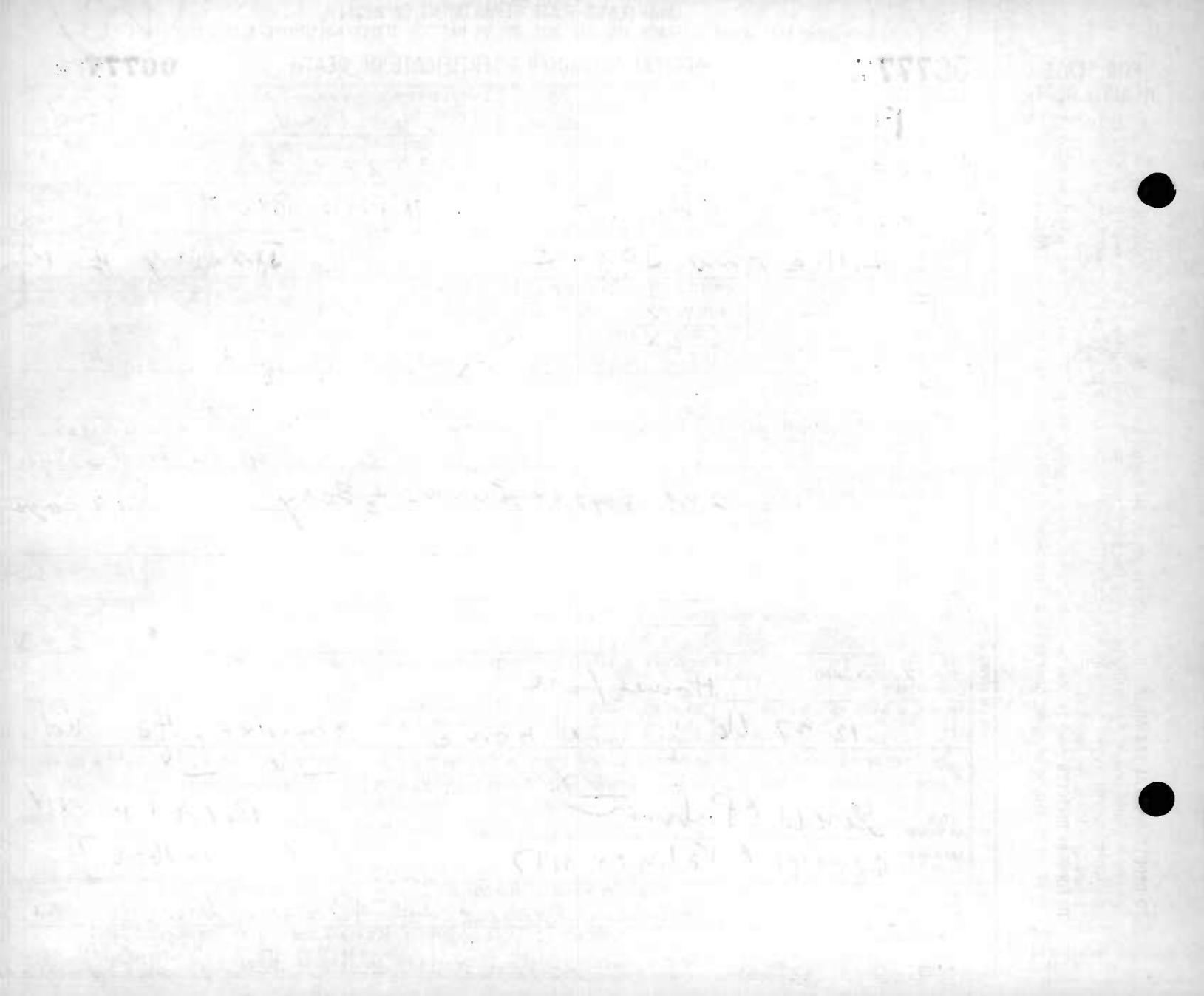
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00777

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00777

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
Harford MARYLAND		Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) House of Justice		c. LENGTH OF STAY IN 1b 19 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen	
3. NAME OF DECEASED (Type or print) Lillie Ann Jones		d. STREET ADDRESS North Phila. Blvd	
First		Middle	Lost
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH Month Year January 15 67	
5. SEX F		6. COLOR OR RACE e	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Jan. 1, 1871	
9. AGE (In years lost birthday) 96 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping Dept		10b. KIND OF BUSINESS OR INDUSTRY V.A. Hospital	
11. BIRTHPLACE (State or foreign country) Harford County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Barney Smith		14. MOTHER'S MAIDEN NAME Amelia McComas	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mr. John Peery, Stepney Rd, Aberdeen, Md.		Address Etch, Box 88	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2nd Degree Burns to Body 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 19 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) House fire	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 12-27 66 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Aberdeen, Harford Co. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 1-16-67	
ACTUAL SIGNATURE Gerald C Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 1-16-67	
EXAMINER'S NAME (Type) Gerald C Palmer		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF Jan. 19, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Union Methodist Cem.	
24. FUNERAL DIRECTOR Otilie J. Bullock, Starke de Gray, Md.		23d. LOCATION (City or Town) (County) (State) Aberdeen, Harford Co. Md.	
ADDRESS 556 Avenue St.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE JAN 20 1967	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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00778

CERTIFICATE OF DEATH

00778

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to a burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Street		c. LENGTH OF STAY IN 1b 57 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.#2		d. STREET ADDRESS R.D.#2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BESSIE Middle MARY Last KOHLBUS		4. DATE OF DEATH Month January Day 7, Year 1967	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH June 25, 1889		9. AGE (In years last birthday) 77 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Constitution, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Flaharty		14. MOTHER'S MAIDEN NAME Ada Orr	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-30-6283	
17. INFORMANT Mrs. Paul Iddings, Street, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420.1</u>		INTERVAL BETWEEN ONSET AND DEATH sudden,	
(b) <u>Advanced hypertension arteriosclerotic cardiovascular disease</u> DUE TO (c)		10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic pyelonephritis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>7 Jan</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7 Jan</u> 19 <u>67</u> , and that death occurred at <u>2:40 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edwin W. Whiteford, Jr. M.D.</u>		22b. DATE SIGNED Jan. 7, 1967	
22c. PHYSICIAN'S NAME (Type) Edwin W. Whiteford, Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 9, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL Emory		23d. LOCATION (City or Town) (County) (State) Street Harford Md.	
24. FUNERAL DIRECTOR <u>John H. Hopkins</u>		ADDRESS Delta, Pa.	
		25a. REC'D BY REGISTRAR Charles Judge	
		25b. REGISTRAR'S SIGNATURE DATE JAN 10 1967	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

00780

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00780

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

5 may be retained for your files.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Darlington</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>1</i>		d. STREET ADDRESS <i>R.D. #1</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Hollis</i>		First <i>Hollis</i>	Middle <i>Lewis</i>
4. DATE OF DEATH Month <i>January</i>	Day <i>12</i>	Year <i>1967</i>	
S. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 12, 1901</i>
9. AGE (In years last birthday) yrs. <i>65</i>	10. KIND OF BUSINESS OR INDUSTRY <i>LUMBER</i>	11. BIRTHPLACE (State or foreign country) <i>ASHE Co., N.C.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>NATHAN LEWIS</i>	14. MOTHER'S MAIDEN NAME <i>FRONIE ASBORNE</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>302-03-4542</i>	17. INFORMANT <i>HARVEY LEWIS, Darlington, Md.</i>	Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>910.3</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Stack laundry fell on him</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>4</i> a.m. <i>1-12-67</i> p.m. <i>6</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Blue Ridge Flours Co, Darlington, H2, Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Harold C Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. <i>Be/4/17</i>	
EXAMINER'S NAME (Type) <i>Harold C Palmer, Md.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <i>1-13-67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>JAN. 15, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>DUBLIN SOUTHERN</i>		23d. LOCATION (City or Town) (County) (State) <i>DUBLIN, HARFORD Co., Md.</i>	
24. FUNERAL DIRECTOR <i>John H. Harbine, DELTA, PA.</i>		ADDRESS	
25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>JAN 17 1967</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00781

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		Item 9 Film G385 1/24/67 mh		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <i>Md.</i> b. COUNTY <i>Hanover</i>		00781		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Benson</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Benson</i>		d. STREET ADDRESS <i>121</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Annie</i>		First	Middle	Last	4. DATE OF DEATH <i>January 15 1967</i>	Month	Day	Year
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>Apr 29 1879</i>	9. AGE (in years last birthday) <i>87</i>	10. IF UNDER 1 YEAR Months <i>8</i>	11. IF UNDER 24 HRS. Days <i>7</i>	Hours <i>8</i>	Min. <i>00</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>retired</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Harford Co. Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Edward Lingan</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Wright</i>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>		17. INFORMANT <i>Margaret Ruth Weaver</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerosis</i> DUE TO <i>422.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Baltimore</i> (County) <i>Md.</i> (State) <i>Md.</i>
21. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>1-10</i> to <i>1-15</i> , 1967, that (I) <i>(we)</i> last saw the deceased alive on <i>1-10</i> , 1967, and that death occurred at <i>M</i> , from the causes and on the date stated above.		22a. SIGNATURE <i>Bernell E Palmer</i>		22b. DATE SIGNED <i>1-16-67</i>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <i>Bernell E Palmer</i>		22d. ADDRESS <i>6211 1/2 E Palmer Rd Bel Air Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan 18 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>St. John's Catholic</i>		23d. LOCATION (City, town or county) <i>Long Green</i> (State) <i>Md.</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Archer</i>		ADDRESS <i>Benson Md.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
VR A15 (4) 15M 7-62				DATE JAN 19 1967				

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

M

00782

CERTIFICATE OF DEATH

00782

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington (Rural)				b. COUNTY Harford			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington (Rural) 12.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #2,				d. STREET ADDRESS 250 Route #2, Box 220			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) GEORGE OSCAR MAYS				4. DATE OF DEATH Month January 7, 1967			
5. SEX Male		6. COLOR OR RACE Cau.		7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4 March 1886	
9. AGE (In years last birthday) 80 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Ret.)		11. KIND OF BUSINESS OR INDUSTRY Farm		12. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Harvey Mays				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 209-12-5527			
17. INFORMANT Curtis Price, Darlington, Maryland				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO Pericarditis Vasculitis Accident INTERVAL BETWEEN Conditions, if any, which gave ONSET AND DEATH rise to immediate cause (a), stating the underlying cause (b) lost. Generalized Arthrosclerosis 26m							
DUE TO Generalized Arthrosclerosis 5 yrs							
DUE TO Hypertension							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bel Air Memorial Gardens, Bel Air, Md.	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1/20/67 to 1/7/67 , that (I) (we) last saw the deceased alive on 1/4/67 , and that death occurred at 9:40 A.M. from causes and on the date stated above.							
22a. SIGNATURE Dudley Phillips				22b. DATE SIGNED 1/8/67			
22c. PHYSICIAN'S NAME (Type) Dudley Phillips, M.D.				22d. ADDRESS Darlington, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10 Jan. 67		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Bel Air Memorial Gardens, Bel Air, Md.		23d. LOCATION (City or Town) (County) (State) Bel Air, Md.	
24. FUNERAL DIRECTOR Helen Macomber Jr.		24b. ADDRESS Tarring Funeral Home Aberdeen, Md.		24c. RECD BY REGISTRAR JAN 11 1967		24d. REGISTERED & SIGNATURE James Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00783

CERTIFICATE OF DEATH**00783**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 00783																			
		PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace c. LENGTH OF STAY IN 1b 18 months					USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford														
		b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air d. STREET ADDRESS 2 Lynwood Court					c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air d. STREET ADDRESS 2 Lynwood Court														
		3. NAME OF DECEASED First Margaret Middle Harold Last McWilliam					e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>														
		4. DATE OF DEATH January 18, 1967					e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>														
		5. SEX Female		6. COLDLR DR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH June 14, 1885		9. AGE (in years at last birthday) 81 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>									
						WIDOWED <input checked="" type="checkbox"/> DIVDRCD <input type="checkbox"/>															
		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS DR INDUSTRY Homemaker					11. BIRTHPLACE (County & State, or foreign country) Glasgow, Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
		13. FATHER'S NAME William Robertson					14. MOTHER'S MAIDEN NAME Hannah Couborough														
		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY ND. NCNE					17. INFRMRNT Son 838-7463 Mr. John R. McWilliam Address 2 Lynwood Court Bel Air, Md. 21014									
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Inanition (② bronchopneumonia 450.0 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. generalized arteriosclerosis					DUE TO (b) generalized arteriosclerosis DUE TO (c) generalized arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH ① 6 wks ② 20 yrs									
		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fracture R. hip										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) 20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
		21. I certify that (I) (this hospital) attended the deceased from July 3, 1965 to January 18, 1967 , that (I) (we) last saw the deceased alive on Jan 17, 1967 , and that death occurred at 10:05 P.M. from the causes and on the date stated above.																			
		22a. SIGNATURE B. J. Plunkett Jr.										22b. DATE SIGNED Jan. 19, 1967									
		22c. PHYSICIAN'S NAME (Type) Barry J. Plunkett, Jr. M.D.					22d. ADDRESS 617 W. Bel Air Ave. Aberdeen, Maryland														
		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Jan. 21, 1967					23c. NAME OF CEMETERY OR CREMATORIUM Oak Grove Cemetery					23d. LOCATION (City, town or county) (State) FALL RIVER, MASS.				
		24. FUNERAL DIRECTOR Joseph William Foster					ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014					25a. REC'D BY REGISTRAR Charles Judge DATE JAN 23 1967					25b. REGISTRAR'S SIGNATURE Charles Judge				

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00784

CERTIFICATE OF DEATH

00784

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 128 N. Philadelphia Blvd.		d. STREET ADDRESS 128 N. Philadelphia Blvd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH Month January Day 2 Year 19 67	
3. NAME OF DECEASED (Type or print)	First BEATRICE	Middle LONG	Last MILLER
S. SEX Female	6. COLOR OR RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6 April 1912
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Long		14. MOTHER'S MAIDEN NAME Myrtle Simpson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Ralph J. Miller, Aberdeen, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) pulmonary edema		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) arteriovenous heart disease DUE TO (c) pyelonephritis DUE TO		3 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) pyelonephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-26-66 , 19, to 1-2-67 , 19, that (I) (we) last saw the deceased alive on 1-2-67 , 19, and that death occurred at 1:40 P.M. from causes and on the date stated above.		22b. DATE SIGNED 1-2-67	
22a. SIGNATURE B. J. Plunkett Jr.		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS 617 W. Bel Air Ave. Aberdeen, Md.
22c. PHYSICIAN'S NAME (Type) B. J. Plunkett Jr. M.D.		23d. LOCATION (City or Town) (County) (State) Aberdeen, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4 Jan. 67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St Paul Lutheran Cemetery, Aberdeen, Md.
24. FUNERAL DIRECTOR Welsch Mortuaries, Aberdeen, Md.		25a. REC'D BY REGISTRAR DATE JAN 6 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00785

CERTIFICATE OF DEATH

00785

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE			
<i>Harford</i>		MARYLAND			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b			
<i>Havre de Grace</i>		2 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM?			
<i>Harford Memorial Hospital</i>		12-1			
16b		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle		
<i>Katherine</i>		<i>Marie</i>	<i>Milke</i>		
4. DATE OF DEATH		Month	Day Year		
		JANUARY	14 1967		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) IF UNDER 1 YEAR 76 yrs. Months Days Hours Min.
<i>Female</i>		<i>White</i>		<i>19 Dec. 1890</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
<i>Housewife</i>		<i>Home</i>		<i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY?				<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
<i>George Oberdorffer</i>		<i>Amelia Leeblein</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
<i>No</i>		<i>212-48-6569</i>		<i>Katherine M. Peery, Aberdeen, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Acute Suppurative Thoracic Thoracitis</i>			
<i>570.2</i>		<i>2 days.</i>			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)		<i>Generalized Chorioconjunctivitis</i>	
		DUE TO (c)		<i>unknown.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>JAN. 12, 1967</i> to <i>JAN. 14, 1967</i> , that (I) (we) last saw the deceased alive on <i>JAN. 14, 1967</i> , and that death occurred at <i>945 M.</i> from the causes and on the date stated above.		22b. DATE SIGNED <i>Jan. 14, 1967</i>			
22a. SIGNATURE <i>M. W. ISHAK, M.D.</i>		22d. ADDRESS <i>Havre de Grace, Maryland</i>			
22c. PHYSICIAN'S NAME (Type)		23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			
		23b. DATE THEREOF <i>17 Jan. 67</i>			
		23c. NAME OF CEMETERY OR CREMATORIAL <i>Angel Hill Cemetery</i>			
24. FUNERAL DIRECTOR <i>John J. Corrigan</i>		23d. LOCATION (City, town or county) (State) <i>Havre de Grace, Maryland</i>			
		25a. REC'D BY REGISTRAR DATE <i>JAN 17 1967</i>			
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

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00786

CERTIFICATE OF DEATH

00786

1. PLACE OF DEATH
a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Havre de Grace

c. LENGTH OF STAY IN 1b

12 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Harford Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

Thelma Whitney Minster

JANUARY 21 1967

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS

Female

White

WIDOWED DIVORCED

12 - 9 - 1908

58 yrs.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)10b. KIND OF BUSINESS OR
INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

SECRETARY

PHOTO SHOP

HARVE DE GRACE, MD.

cl. SA.

13. FATHER'S NAME

HARRY C. WHITNEY

14. MOTHER'S MAIDEN NAME

SADIE EPXONDSO^N15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

No

JPCOB T. MINSTER HARVE DE GRACE

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

5811

Gastrointestinal hemorrhage & encephalopathy

INTERVAL BETWEEN
ONSET AND DEATH

days

Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO

(b)

Alcoholic cirrhosis & Anemia. Intoxication

years

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County) (State)

19

21. I certify that (I) (this hospital) attended the deceased from 1-10, 1967, to 1-21, 1967, that (I) (we) last
saw the deceased alive on 1-21 1967, and that death occurred at 1:54 AM, from the causes and on the date stated above.

22a. SIGNATURE

C. W. Grigoleit

22b. DATE SIGNED

1/21/67

22c. PHYSICIAN'S
NAME (Type)

A. W. Grigoleit

22d. ADDRESS

HARVE de GRACE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORIUM

23d. LOCATION (City, town or county) (State)

Burial

1-24-67

BILPIN MANOR MEM. PK. EKTON MD.

24. FUNERAL DIRECTOR

Robert F. Sand

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

PIPPIN FUNERAL HOME

BLADON MD

DATE

JAN 24 1967

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2200

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and my event within 72 hours after death.

**FOR STATE
HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00787

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00787

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Darlington</i>		c. LENGTH OF STAY IN lb <i>20 yrs.</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Darlington</i>		d. STREET ADDRESS <i>121</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARYLAND</i>		First <i>V.</i>	Middle <i>Murphy</i>
4. DATE OF DEATH Month <i>January</i>	Year <i>1967</i>	Month <i>January</i>	Year <i>1967</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 3, 1910</i>
9. AGE (In years last birthday) <i>56</i> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Conowingo, Md.</i>
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	13. FATHER'S NAME <i>ESTIL Root</i>	14. MOTHER'S MAIDEN NAME <i>AUGUSTA GRIEST</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <i>No</i>
16. SOCIAL SECURITY NO.	17. INFORMANT <i>JOHN C. MURPHY, JR., DARLINGTON, Md.</i>	Address	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>2nd degree burns entire body</i> DUE TO 916.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>12:15 1-5 1967</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>
20f. (City or town) <i>Darlington</i>		(County) <i>Harford</i>	(State) <i>Md.</i>
22. DATE SIGNED <i>Gerald C Palmer</i>		23. ACTUAL SIGNATURE <i>Gerald C Palmer</i>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer</i>		M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>1-7-67</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>DARLINGTON</i>
24. FUNERAL DIRECTOR <i>John H. Hardin</i>		ADDRESS <i>DELTA, Pa.</i>	25a. REC'D BY REGISTRAR DATE <i>JAN 9 1967</i>
25b. REGISTRAR'S SIGNATURE <i>Debbie Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00788

CERTIFICATE OF DEATH

00788

1. PLACE OF DEATH a. COUNTY <i>Harford</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Md</i>	b. COUNTY <i>Harford</i>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Harve de Grace</i>	c. LENGTH OF STAY IN 1b <i>5 days</i>	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>	d. STREET ADDRESS 14 N. Williams St. <i>Box 230</i>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	12.1		
3. NAME OF DECEASED (Type or print) <i>Mary</i>	First <i>Mary</i>	Middle <i>Madeleine</i>	Last <i>O'Neill</i>	4. DATE OF DEATH <i>JANUARY 23 1967</i>	Month Day Year
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 30, 1888</i>	9. AGE (In years at last birthday) <i>78</i>	10. IF FUNDER 1 YEAR / IF FUNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Homemaker</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Harford Co., Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Thomas Hall Robinson</i>	14. MOTHER'S MAIDEN NAME <i>Clara Cain</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>	16. SOCIAL SECURITY NO. <i>213-46-3966</i>	17. INFORMANT (SIN) 838-3300 Mr. Harry St. A. O'Neill	Address <i>1 Wall Street Bel Air, Md. 21014</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i>	INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>				
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive + Atherosclerotic</i>					
DUE TO (c) <i>Cardiovascular Disease</i>	3-4 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pneumonitis and peripheral Arteriosclerosis</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>White at work</i>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED <i>White at work</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Woudon Park Cemetery</i>	20f. (City or town) <i>Bel Air</i>	(County) <i>Harford Co.</i>	
20g. (State) <i>Md.</i>					
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 19th, 1967</i> to <i>Jan. 23, 1967</i> that (I) (we) last saw the deceased alive on <i>Jan. 23rd 1967</i> , and that death occurred at <i>Bel Air</i> M, from the causes and on the date stated above.	22a. SIGNATURE <i>Edward C. Loo</i>	22b. DATE SIGNED <i>1/23/67</i>			
22c. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>	22d. ADDRESS <i>Harve de Grace, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Jan. 26, 1967</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Woudon Park Cemetery</i>	23d. LOCATION (City, town or county) <i>3801 Frederick Ave. Baltimore, Md. 21201</i>	(State)	
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>	ADDRESS <i>W. Broadway & Williams St. Bel Air, Maryland 21014</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	DATE <i>JAN 25 1967</i>	
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00789

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

2. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	
HARFORD MARYLAND		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
HARFORD		3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
HARFORD Memorial Hospital			
66			
3. NAME OF DECEASED (Type or print)		First	Middle
Christine		—	—
4. DATE OF DEATH		Month	Day
Neckee		JANUARY	9
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
F		W	
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
Nov. 8, 1882		84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)
Housewife		none	Md
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
US		Henry Neumeister	
14. MOTHER'S MAIDEN NAME		Louise Knoblock	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT
No		216-48-1054	Mrs. Wm. Fertig, 2112 Trimble Road, Edgewood
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Md.	
4221 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3-4 days (Several mo.)	
DUE TO (b)			
DUE TO (c)			
Acute cardiac failure due to severe gen. ASCVD.			
Acute & Chronic clns.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
megacolon - megarectum			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
19			20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 1-9-1967, that (I) (we) last saw the deceased alive on 1-9-1967, and that death occurred at 11A M, from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE		22b. DATE SIGNED	
HENRY H. KWAK		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
HENRY H. KWAK		608 S. Union Ave. Harford Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		Jan. 12, 1967	
23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county) (State)	
Bel Air Memorial Gardens		Bel Air Harford Md.	
24. FUNERAL DIRECTOR		25a. ADDRESS	
Howard K. McComas & Son,		Abingdon, Md.	
25b. REGISTRAR'S SIGNATURE		Charles Judge	
DATE JAN 12 1967			

02800

1000 METRES

1 M
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00790

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00790

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i> <i>Grace</i> <i>300 AVS</i>		c. LENGTH OF STAY IN lb <i>300 AVS</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i> <i>Grace</i> <i>121</i>	
3. NAME OF DECEASED (Type or print) <i>Bertrice Estelle PAH</i>		d. STREET ADDRESS <i>324 N. Union Ave.</i>	
5. SEX <i>F</i> 6. COLOR OR RACE <i>W</i>		4. DATE OF DEATH <i>January 5 1967</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Nov. 25, 1880</i> 9. AGE (In years last birthday) <i>86</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <i>HOUSEWIFE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	
11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>SILAS S. WHITELOCK</i>		14. MOTHER'S MAIDEN NAME <i>LILLIAN STANDIFORD</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>216-24-7026</i> 17. INFORMANT <i>EDWARD S. WARD</i> Address: <i>78345 13 BRIDGES LANE DUNDALK, MD 21222</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fractional Femur</i>		INTERVAL BETWEEN ONSET AND DEATH	
904.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not White <input type="checkbox"/> at work <i>2</i> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Breva Nursing Home</i> 20f. (City or town) <i>Harford</i> (County) <i>Grace</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Gerald C Palmer</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Baltimore, Md.</i> 22. DATE SIGNED	
EXAMINER'S NAME (Type) <i>Gerald C Palmer MD</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <i>1-6-67</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>JAN. 8, 1967</i> 23c. NAME OF CEMETERY OR CREMATORIAL <i>ANGEL HILL CEM.</i> 23d. LOCATION (City or Town) <i>HARFORD</i> (County) <i>Grace</i> (State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>R. Madison Mitchell</i>		ADDRESS <i>HARFORD</i> 25a. REC'D BY REGISTRAR <i>Charles Judge</i> 25b. REGISTRAR'S SIGNATURE DATE <i>JAN 10 1967</i>	

OCTOBER

1968

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00791

CERTIFICATE OF DEATH

00791

Items 8, 9, 10, 14 G385 2/5/67 mb

CERTIFICATE OF DEATH

executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or attending physician.

23

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)	
Harford		a. STATE Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Harford	
Havre de Grace		c. LENGTH OF STAY IN 1b 35 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 119 Market St.	
Harford Memorial		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Last Month Day Year	
Annie Margaret Patrick		1894 8 1967	1. DATE OF BIRTH 8 1967
5. SEX F		6. COLOR OR RACE W	
7. MARRIED WIDOWED		8. DATE OF BIRTH DIVORCED	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) 707d		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Kelly		14. MOTHER'S MAIDEN NAME Mary Kelly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 200		16. SOCIAL SECURITY NO. 111-11-1111	
17. INFORMANT Howard Bullock		Address 600 Market St. Harford, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) CVA - Cerebral thrombosis Hypertension A5HD		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bronchopneumonia Hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 20, to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 9 1/2 M, from the causes and on the date stated above.			
22a. SIGNATURE Santiago Leyte-Vidal		22b. DATE SIGNED 1-8-66	
22c. PHYSICIAN'S NAME (Type) Santiago Leyte-Vidal		22d. ADDRESS 114 W. 3rd St. Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1/11/67	
23c. NAME OF CEMETERY OR CREMATORIAL Harford Mem. Gardens		23d. LOCATION (City, town or county) (State) Altona Md	
24. FUNERAL DIRECTOR Perry L. P. Harford, Md.		25a. REC'D BY REGISTRAR DATE JAN 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

12590

12590

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00792

CERTIFICATE OF DEATH

00792

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or repatriation, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		c. LENGTH OF STAY IN 1b 50 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Long Bar Harbor		d. STREET ADDRESS Long Bar Harbor			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) FLORENCE		First ESTELLE	Middle RATCLIFFE	4. DATE OF DEATH JANUARY 2 1967	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Samuel Burns Ratcliffe		14. MOTHER'S MAIDEN NAME Florence Hoffner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220-44-6007		17. INFORMANT Donald B. Ratcliffe, 917 Army Road, Towson 4	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Primary lesion - not known.		b. Carcinomatosis in abdomen		INTERVAL BETWEEN ONSET AND DEATH	
(b) DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senility and A.S. C.V.D.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) While at work			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 211 N. Union Ave., Havre de Grace, Md.	
21. I certify that (I) (this hospital) attended the deceased from Sept 20, 1966 to Jan 2, 1967 , that (I) (we) last saw the deceased alive on Jan 2nd 1967 , and that death occurred at 211 N. Union Ave., Havre de Grace, Md. from causes and on the date stated above.					
22a. SIGNATURE Edward Loo, M.D.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Jan. 2nd. 67	
22c. PHYSICIAN'S NAME (Type) Edward Loo, M.D.		22d. ADDRESS 211 N. Union Ave., Havre de Grace, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 5, 1967		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Loudon Park Cemetery	
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009				25a. RECD BY REGISTRAR Charles Judge	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00793

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harve de Grace</i>		c. LENGTH OF STAY IN 1b <i>7 hours</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Talmage</i>	Middle <i>Samuel</i>	Last <i>Richardson</i>
4. DATE OF DEATH <i>JANUARY 22 1967</i>	Month Day Year		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 15, 1906</i>
9. AGE (In years last birthday) <i>60 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanic</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Auto</i>	11. BIRTHPLACE (County & State, or foreign country) <i>W. Jefferson, North Carolina</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	13. FATHER'S NAME <i>Jonah Richardson</i>		
14. MOTHER'S MAIDEN NAME <i>Leona Roberts</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		
16. SOCIAL SECURITY NO. <i>216-18-0259</i>	17. INFORMANT <i>Mr. Jerrel Richardson, 20B Cedar Drive, Baltimore, Md.</i>	Address <i>Baltimore, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac tamponade.</i>			
DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
DUE TO (c) Injury or disease, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Rupture of the myocardium Intracardiac infarction</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>
20f. (City or town) <i></i>		(County) <i></i>	
(State) <i></i>			
21. I certify that (I) (this hospital) attended the deceased from <i>JANUARY 22 1967</i> to <i>JANUARY 22 1967</i> , that (I) (we) last saw the deceased alive on <i>JANUARY 22 1967</i> , and that death occurred at <i>11:35 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Mezes</i>		22b. DATE SIGNED <i>Jan. 23, 1967</i>	
22c. PHYSICIAN'S NAME (Type) <i>Lajos Mezes</i>		22d. ADDRESS <i>Havre de Grace, Harford Co., Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan. 25, 1967</i>	
23c. NAME OF CEMETERY OR CREMATORIAL <i>Bel Air Memorial Gardens</i>		23d. LOCATION (City, town or county) (State) <i>Bel Air Harford Md</i>	
24. FUNERAL DIRECTOR <i>Howard K. McComas & Son, Abingdon, Md. 21009</i>		25a. ADDRESS <i></i>	
25b. REC'D BY REGISTRAR <i>Charles Judge</i>		REGISTRAR'S SIGNATURE <i>JAN 25 1967</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00794

CERTIFICATE OF DEATH

00794

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff		c. LENGTH OF STAY IN lb 82 yrs.						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Cardiff						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First Mary		Middle E.	4. DATE OF DEATH Lost Ross Month January Day 27 Year 1967					
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 1, 1884	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Harford Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Parry			14. MOTHER'S MAIDEN NAME Carrie Stull					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mabel Love Address Delta, R.D., Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) - PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriovenous Dicongenital</i> INTERVAL BETWEEN DUE TO <i>Arteriovenous Dicongenital</i> ONSET AND DEATH <i>422.1</i> <i>1967</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriovenous Dicongenital</i> (c) <i>Arteriovenous Dicongenital</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>Jan 27, 1967</i> , to <i>Jan 27, 1967</i> , that (I) (we) last saw the deceased alive on <i>Jan 27, 1967</i> , and that death occurred at <i>3A</i> M from causes and on the date stated above.								
22a. SIGNATURE <i>Josiah A. Hunt M.D.</i>								
22c. PHYSICIAN'S NAME (Type) <i>Josiah A. Hunt M.D.</i>		22d. ADDRESS Delta, Pa.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 29, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Slate Ridge		23d. LOCATION (City or Town) (County) (State) Delta, York Co., Pa.		
24. FUNERAL DIRECTOR <i>John H. Hartins</i>		ADDRESS Delta, Pa.		25a. REC'D BY REGISTRAR JAN 31 1967		26b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
20 M 1/66				DATE				

56700

40900



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00795

CERTIFICATE OF DEATH

00795

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		100A		a. STATE Md b. COUNTY Harford	
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Harford Memorial Hospital		d. STREET ADDRESS 610 Erie St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH Month Day Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 11/30/1913	9. AGE (In years last birthday) 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Unemployed Labour		11. BIRTHPLACE (County & State, or foreign country) Roseland Va.	
13. FATHER'S NAME Harry T Sprouse		14. MOTHER'S MAIDEN NAME Lottie Davidson		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 44-12-1212		17. INFORMANT Bernard Sprouse 610 Erie St., Harford, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		ADDRESS			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201		INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Rheumatic Carditis			
DUE TO		(c) Arteriosclerotic Heart disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/27, 1962, to 11/28, 1967, that (I) (we) last saw the deceased alive on 11/26, 1967, and that death occurred at 3:10 P.M., from the causes and on the date stated above.		22b. DATE SIGNED 11/28/67			
22a. SIGNATURE George T. Stansbury		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11/28/67
22c. PHYSICIAN'S NAME (Type) George T. Stansbury		22d. ADDRESS 509 Revolution St. Harford Grace, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 12/1/67		23c. NAME OF CEMETERY, OR CREMATORIAL Angel Hill		23d. LOCATION (City, town or county) (State) Hanover, Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE FEB 1 1967 Charles Judge	

38100

22200

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00796

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY	Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE	Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Harve de Grace 4 days.		c. LENGTH OF STAY IN 1b	b. COUNTY			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Harford Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	White Ford 12-1			
3. NAME OF DECEASED (Type or print)	Gustine	Middle	Last	4. DATE OF DEATH	Month Day Year		
SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS		
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9/21/1907	59 yrs.	Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?			
House - wife	Own Home		Md.	USA			
13. FATHER'S NAME	George Norris		14. MOTHER'S MAIDEN NAME	Margaret Fake			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.		17. INFORMANT	Address			
No	—		M.F. Strawbridge, Whiteford, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral vascular thrombosis massive		4 days			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		Gluealized Atherosclerotic Cardiovascular disease		3-4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)							
Diabetes mellitus.						19. WAS AUTOPSY PERFORMED?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not-While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that (I) (this hospital) attended the deceased from Jan 2nd, 1967, to Jan 6, 1967, that (I) (we) last saw the deceased alive on Jan 6th, 1967, and that death occurred at M, from the causes and on the date stated above.						22a. SIGNATURE	22b. DATE SIGNED
Edward C. Loo, M.D.						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	1/6/1967
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORIY 23d. LOCATION (City, town or county) (State)			
Burial		St. Paul Cemetery		Pylesville, Harford Co. Md.			
1/10/67		AOORESS		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
24. FUNERAL DIRECTOR		Stewartstown, Penna.		JAN 11 1967 Charles Judge			
Bennett C. Loo		DATE					

3270

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~Item 1 and 2~~ Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. MEDICAL CERTIFICATION 23

00797

CERTIFICATE OF DEATH

00797

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HARFORD		c. LENGTH OF STAY IN lb 2 MONTHS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BREVIN NURSING HOME		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) EDITH R. TREAKLE		4. DATE OF DEATH Month 1	Day Year 5 1967
S. SEX F	6. COLOR OR RACE WH	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH 10-14-83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) HARFORD, MD		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME BASIL TREAKLE		14. MOTHER'S MAIDEN NAME SARAH E. HUFF	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	17. INFORMANT Address Mrs. ELLA SCARFF, BELAIR, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) possibly heart attack		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) (found dead in bed)			
DUE TO (c) A.S.C.V.D			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Dec 25, 1966, to 1-3, 1967
21. I certify that (I) (this hospital) attended the deceased from Dec 25, 1966, to 1-3, 1967 that (I) (we) last saw the deceased alive on 1-3 1967 , and that death occurred at 3A M , from causes and on the date stated above		20f. (City or town) (County) (State)	
22a. SIGNATURE John D. Yar		22b. DATE SIGNED 1/5/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. YAR		22d. ADDRESS HARFORD DE GRACE	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN 7, 1967	23c. NAME OF CEMETERY OR CREMATORIAL EMORY
24. FUNERAL DIRECTOR John H. Harkins, DELTA, PA.		ADDRESS	25a. REC'D. BY REGISTRAR JAN 10 1967
			25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09643

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
o. COUNTY HARFORD MARYLAND		o. STATE UNKNOWN	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FALLSTON		c. LENGTH OF STAY IN lb	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) along State route #152 near Kidd Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Unknown		First Newborn	Middle Male
4. DATE OF DEATH		Month January	Day 26
5. SEX Male		6. COLOR OR RACE ?	7. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years lost birthday) yrs. 19 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 983X DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)		Head injuries	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Abandonment of the newborn, found beside road	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. Unknown 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) highway
20f. (City or town) Fallston (County) Harford (State) Maryland			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED	
ACTUAL SIGNATURE <i>Charles S. Springate</i>		M.D.	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL/CREMATION/REMOVAL (Specify)		23b. DATE THEREOF 7/24/67	
23c. NAME OF CEMETERY OR CREMATORIAL MORGUE MOR 9 WE		23d. LOCATION (City or Town) (County) (State) 7010 F STREET ST	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR DATE JUL 25 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE <i>Charles J. Juge</i>	

1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

00798

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00798

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)	
a. COUNTY Harford MARYLAND		a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN 1b D.O.A.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		d. STREET ADDRESS Revolution Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WARREN Middle S. NATANABE		4. DATE OF DEATH Month January 23 1967	
5. SEX Male		6. COLOR OR RACE Hawaiian	
7. MARRIED WIDOWED Never married		8. NEVER MARRIED DIVORCED Divorced	
9. DATE OF BIRTH 6/31/1928		10. AGE (In years last birthday) 38 yrs.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner Laundry		12. KIND OF BUSINESS OR INDUSTRY Hawaii	
13. FATHER'S NAME Wilfred Watanabe		14. MOTHER'S MAIDEN NAME Blizue Tanka	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Indriyo Watanabe		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Electrocution. DUE TO 914.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19. MEDICAL CERTIFICATION		20. INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Head came in contact with bare wire.	
20c. TIME OF INJURY Month, Day, Year Hour AM 1/23 1967 p.m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Laundry		20f. (City or town) (County) (State) Havre de Grace Harford Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county) Baltimore, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) 1/27/67		23b. DATE THEREOF 1/27/67	
23c. NAME OF CEMETERY OR CREMATORIAL Kensington		23d. LOCATION (City or Town) (County) (State) Baltimore, Md	
24. FUNERAL DIRECTOR Decompton Dr. Havre Grace Md		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE JAN 27 1967	

26700

07-10-1992 02:00:00

26709

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00799

CERTIFICATE OF DEATH

00799

1. PLACE OF DEATH
a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

HAURE de GRACE

c. LENGTH OF STAY IN 1b

26 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

100
Harford Memorial Hosp.

3. NAME OF
DECEASED
(Type or print)

First MIDDLE
Margaret

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Harford

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Aberdeen

12.1

d. STREET ADDRESS

1 EAST INCA

e. IS RESIDENCE
ON A FARM?
YES NO

5. SEX

6. COLOR OF RACE

7. MARRIED NEVER MARRIED
WIDOWED DIVORCED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

4 Dec. 1907

59 yrs.

10. DATE
OF
DEATH

Month Day Year

JANUARY 20 1967

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR
INDUSTRY

Home

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

Portsmouth, Virginia

U.S.A.

13. FATHER'S NAME

Joseph C. O'Dorman

14. MOTHER'S MAIDEN NAME

Nellie Bassett

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

NO

16. SOCIAL SECURITY NO.

218-38-4572

17. INFORMANT

Nellie Tomlinson, Aberdeen, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

199.2 DUE TO

Conditions, If any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO

(c)

ANAPLASTIC CARCINOMA

INTERVAL BETWEEN
ONSET AND DEATH
MONTHS

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 12-26, 1966, to 1-20, 1967, that (I) (we) last saw the deceased alive on 1-20, 1967, and that death occurred at 1145 M, from the causes and on the date stated above.

22a. SIGNATURE

Kleyte Vidal

M.D. ATTENDING PHYS.

MED. DIRECTOR STAFF PHYS.

22b. DATE SIGNED

1-20-67

22c. PHYSICIAN'S
NAME (Type)

Santiago Leyte-Vidal M.D. Aberdeen, Maryland

22d. ADDRESS

23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial

23b. DATE THEREOF
22 Jan. 67

23c. NAME OF CEMETERY OR CREMATORIAL
ADDRESS
Tarring Funeral Home

23d. LOCATION (City, town or county) (State)
Aberdeen, Maryland

24. FUNERAL DIRECTOR

ADDRESS
Walter Malcolm Jr. Aberdeen, Md.

25a. REC'D BY REGISTRAR

JAN 23 1967

DATE

25b. REGISTRAR'S SIGNATURE

Charles Judge

100

1 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00800

CERTIFICATE OF DEATH

00800

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hrs after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove Carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 5th day		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE		b. COUNTY	
Harford		MARYLAND				Md.		Cecil	
Harford de Grace						Colona		07-2	
Harford Memorial Hospital									
66									
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Welby		Owen		White	JANUARY	17	1967		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years) last birthday	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS		
Male		White	WIDOWED <input type="checkbox"/>	Divorced <input type="checkbox"/>	JAN 21 1902 64	Yrs.	Months Days Hours Mins.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY			
Storekeeper Ret. Selz		Employed		Casey Creek Ky.		U. S. A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Merton Everett White		Altona Wb17ord							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO		912-22-6527R		Mrs Welby White		Cobrag Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA of Lungs									
DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) _____ (c) _____									
DUE TO OUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of item 18.)									
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
Hour	a.m.		While at work <input type="checkbox"/>	Not While at work <input type="checkbox"/>					
p.m.		19							
21. I certify that (I) (this hospital) attended the deceased from JAN 13, 1967, to JAN 17, 1967, that (I) (we) last saw the deceased alive on JAN 17, 1967, and that death occurred at 12 PM, from the causes and on the date stated above.									
22a. SIGNATURE		22b. DATE SIGNED							
Dudley Phillips M.D.		ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	1/17/67				
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS							
Dudley Phillips M.D.		DARLINGTON MD							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county)				
Burial		1-19-1967	New Bridge Baptist & Rising Sun Cecil Md.		(State)				
24. FUNERAL DIRECTOR		ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE					
Jernon McMillen		Rising Sun Md.							
			DATE JAN 19 1967	Charles Juge					

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00801

CERTIFICATE OF DEATH

00801

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HARFORD		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MD.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. LENGTH OF STAY IN 1b LIFE				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 133 WEBER, ST.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE				
3. NAME OF DECEASED (Type or print) FLORENCE CALVA		4. DATE OF DEATH Month Day Year JAN. 6 1967				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1896			
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months Deys Hours Min. 0 0 0 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOOSER WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME				
11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S. A.				
13. FATHER'S NAME EARNEST. HAYS GIBSON		14. MOTHER'S MAIDEN NAME MARY ELIZABETH HACKNEY				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 215-56-1129				
17. INFORMANT FREDERICK H. WIEMERT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A. S. C. V. D. DUE TO: (c) —				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Sudden 6-7 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ① Diabetes mellitus ② Acute gastritis						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) —				
20c. TIME OF INJURY Hour e.m. —	Month, Day, Year Sept. 11 1959	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —
21. I certify that (I) (this hospital) attended the deceased from Sept. 11 1959 to Jan. 6th 1967 , that (I) (we) last saw the deceased alive on Jan. 6th 1967 , and that death occurred at 9 P.M. from the causes and on the date stated above.						
22a. SIGNATURE Edward C. Loo, M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/9/67		
22c. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		22d. ADDRESS Havre de Grace, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 9 1967		23c. NAME OF CEMETERY OR CREMATORIAL ANGEL HILL CEM.		23d. LOCATION (City, town or county) HAVRE DE GRACE
24. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell, Havre de Grace, Md.		ADDRESS		25e. REC'D BY REGISTRAR DATE JAN 10 1967		25b. REGISTRAR'S SIGNATURE Charles J. ...

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00802

CERTIFICATE OF DEATH

00802

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE	
<i>Harford</i> MARYLAND		<i>Md</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harve de Grace</i>		c. LENGTH OF STAY IN 1b <i>1 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>		d. STREET ADDRESS <i>Calvary Road</i>	
3. NAME OF DECEASED (Type or print)		First <i>Laura</i>	Middle <i>Mae</i>
3. NAME OF DECEASED (Type or print)		Last <i>Wilmouth</i>	4. DATE OF DEATH Month <i>JANUARY</i> Day <i>4</i> Year <i>1967</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>3 Dec. 1892</i>		9. AGE (In years last birthday) <i>74</i> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> No		16. SOCIAL SECURITY NO. <i>229-48-3056</i>	17. INFORMANT Address <i>Louis B. Wilmouth, Churchville, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) Cerebro-vascular accident Orteous clausis Pubis			
INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1 - 3</i> , 19 <i>67</i> , to <i>1 - 4</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>1 - 4</i> , 19 <i>67</i> , and that death occurred at <i>4321</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Irvin L. Wachsman, M.D.</i>		22b. DATE SIGNED <i>1/4/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Irvin L. Wachsman, M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS <i>Habre de Grace, Maryland</i>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>7 Jan. 67</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Bel Air Memorial Gardens</i>
24. FUNERAL DIRECTOR <i>Charles J. Wachsman, Jr.</i>		25a. ADDRESS <i>Tarring Funeral Home</i>	
24. FUNERAL DIRECTOR <i>Charles J. Wachsman, Jr.</i>		25b. REC'D BY REGISTRAR <i>JAN 9</i>	25b. REGISTRAR'S SIGNATURE <i>Charles J. Wachsman, Jr.</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00803

00803

1. PLACE OF DEATH
a. COUNTY

Harford

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

HAURE DE GRACE

c. LENGTH OF STAY IN 1b

5 days

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

16 HARFORD MEMORIAL HOSPITAL 295 PARADISE RD

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS

Months

Days

Hours

Min.

FEMALE

WHITE

WIDOWED

DIVORCED

11 April 1904

62

Yrs.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR
INDUSTRY

Housewife

Home

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT
COUNTRY?

Harford County, Md.

U.S.A.

13. FATHER'S NAME

John G. F. Morlok

14. MOTHER'S MAIDEN NAME

Rozelia A. DeMartin

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Address

George E. Wirsing, Aberdeen, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Pulmonary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

short

4/11
Conditions, if any, which
gave rise to Immediate
cause (a), stating the
underlying cause last.

DUE TO

(b)

OU TO

(c)

Acute Passive Congestion of Internal Organs

Calcific Aortic Stenosis - probably Rheumatic

2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?

YES NO

20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.

20d. INJURY OCCURRED
While at work Not While at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

19

1950

1950

1950

1950

21. I certify that (I) (this hospital) attended the deceased from [REDACTED] 1967 to JAN. 3 1967, that (I) (we) last saw the deceased alive on JAN. 2 1967, and that death occurred at 3:52 M, from the causes and on the date stated above.

22b. DATE SIGNED

1-3-67

22a. SIGNATURE

22c. PHYSICIAN'S
NAME (Type)

M.D. ATTENDING
PHYS.

M.D.
DIRECTOR

STAFF
PHYS.

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)

23c. NAME OF CEMETERY OR CREMATOR

23d. LOCATION (City, town or county) (State)

Burial

5 Jan. 67

St Paul Lutheran

Aberdeen, Maryland

24. FUNERAL DIRECTOR

ADDRESS

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

Walter Beauchamp Jr.

Tarring Funeral Home

JAN 6 1967

Charles J. [Signature]

16

DATE

60600

60600

So don't think I

... will come to you,

1 M

FOR STATE
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00804

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00804

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace, Md. DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Robert First F Middle Wise		4. DATE OF DEATH Month January Doy 14 Year 1967		
S. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 26, 1905	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY -----		
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Robert F. Wise, Sr.		14. MOTHER'S MAIDEN NAME Sarah Turner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-05-5411		
17. INFORMANT Mrs. Mary Wise, Port Deposit, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular Disease INTERVAL BETWEEN ONSET AND DEATH 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Doy, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Bel Air (County) Md. (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE Gerald C. Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED January 14, 1967
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/18/1967	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Jones Mem. Cemetery	23d. LOCATION (City or Town) (County) (State) Port Deposit, Md. Cecil
24. FUNERAL DIRECTOR See G. Patterson & Son, Perryville, Md.		25a. REC'D BY REGISTRAR DATE JAN 23 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jones

verifying work

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												00805		
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harve de Grace</i>				c. LENGTH OF STAY IN 1b <i>2 days</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>				12.1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>				d. STREET ADDRESS <i>Box 239-A Rd 2</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First <i>Phillip</i>	Middle <i>Rodman</i>	Last <i>Woodworth</i>	4. DATE OF DEATH <i>JANUARY 23 1967</i>		Month Year	Day	Year					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN. 5, 1932</i>		9. AGE (In years last birthday) <i>35 yrs.</i>	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Livestock Inspector</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Agriculture Dept.</i>				11. BIRTHPLACE (County & State, or foreign country) <i>WEST NEWBURY, MASS.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Ralph M. Woodworth</i>				14. MOTHER'S MAIDEN NAME <i>May H. Brampton</i>										
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)		16. SOCIAL SECURITY NO. <i>420-30-1360</i>		17. INFORMANT (With) <i>838-8010</i> Address <i>Mrs. Carolyn A. Woodworth RFD #2, Box # 239-A Bel Air, Maryland 21014</i>										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>204.1</i>		DUE TO (b) Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Chronic Myelogenous Leukemia</i>		DUE TO (c) —		Rupture of Pedicle of the spleen				INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) <i>Grove Land</i>		(County) <i>Mass.</i>		(State) <i>Mass.</i>		
21. I certify that (I) (this hospital) attended the deceased from <i>1-22</i> , 19 <i>67</i> , to <i>1-23</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>1-23</i> , 19 <i>67</i> , and that death occurred at <i>11:45</i> AM, from the causes and on the date stated above.														
22a. SIGNATURE <i>Edward C. Loo, M.D.</i>				22b. DATE SIGNED <i>1/24/67</i>										
22c. PHYSICIAN'S NAME (Type) <i>Edward C. Loo, M.D.</i>				22d. ADDRESS <i>Harve de Grace, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>JAN. 28, 1967</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>RIVERVIEW Cemetery</i>		23d. LOCATION (City, town or county) <i>Grove Land, Mass.</i>		(State)						
24. FUNERAL DIRECTOR <i>Joseph William Foster</i>				ADDRESS <i>W. Broadway & Williams St Bel Air, Maryland 21014</i>		25a. REC'D BY REGISTRAR <i>Charles J. Jones</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>						
						DATE <i>JAN 26 1967</i>								

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